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Abstract

Despite political change over the past 25 years in Britain there has been an unprecedented national policy focus on the social determinants of health and population-based approaches to prevent chronic disease. Yet, policy impacts have been modest, inequalities endure and behavioural approaches continue to shape strategies promoting healthy lifestyles. Critical public health scholarship has conceptualised this lack of progress as a problem of 'lifestyle drift' within policy whereby 'upstream' *social* contributors to health inequalities are reconfigured 'downstream' as a matter of *individual* behaviour change. While the lifestyle drift concept is now well established there has been little empirical investigation into the social processes through which it is realised as policies are (re)formulated and implementation is localised. Addressing this gap we present empirical findings from an ethnography conducted in a deprived English neighbourhood in order to explore: (i) the local context in the process of lifestyle drift and; (ii) the social relations that reproduce (in)equities in the design and delivery of lifestyle interventions. Analysis demonstrates how and why '*precarious partnerships*' between local service providers were significant in the process of '*citizen shift*' whereby government responsibility for addressing inequity was decollectivised.

Keywords

England, Health Inequalities, Social Determinants of Health, Physical Activity, Obesity, Advanced Liberalism

Introduction

'Sometimes it feels like this. There I am standing by the shore of a swiftly flowing river and I hear the cry of a drowning man. So I jump into the river, put my arms around him, pull him to shore and apply artificial respiration. Just when he begins to breathe, there is another cry for help. So I jump into the river, reach him, pull him to shore, apply artificial respiration, and then just as he begins to breathe, another cry for help. So back in the river again, reaching, pulling, applying, breathing and then another yell. Again and again, without end, goes the sequence. You know, I am so busy jumping in, pulling them to shore, applying artificial respiration, that I have *no* time to see who the hell is upstream pushing them all in.'

Irving Zola explaining the dilemmas of modern medical practice from the perspective of a physician. Quoted by friend John, B. McKinlay (1994: 509)

The prevention parable is often recited in discussions about public health in order to outline the relative merits of upstream (political, economic, social intervention) and downstream (treatment, care, individual behaviour change) approaches to health promotion. The Ottawa Charter (WHO 1986) is widely considered to have marked a new era in public health by shifting emphasis from downstream solutions to upstream intervention. However, critical scholarship has problematised the implementation of new public health approaches that mobilise discourses of individual empowerment and responsibility *over* collective action and structural reform (Smith et al. 2016; Petersen and Lupton 1996).

On the one hand, new public health approaches highlight the significant personal and population health gains that could be achieved by intervening upstream to increase standards of living and facilitate opportunities for people to live healthy lives (Baum 2008). On the other, a tendency to moralise 'healthy lifestyles' as individualised matters, to be paternalistic and to blame the victim helps to explain why new public health interventions often fail to realise this potential (Kottow 2012; Petersen and Lupton 1996). The challenge of ensuring socially-orientated rather than individually-orientated framings of new public health has been complicated by its emergence at a time when neoliberal ideology was gaining ascendancy as the dominant political influence in the West. The detrimental influence of neoliberalism on health inequalities has been well argued (e.g., Coburn 2004; Peacock et al. 2014) alongside calls for more nuanced debates about conceptualising the operation of 'neoliberal' power (Bell and Green 2016).

The pervasiveness of individualised rationalities and market oriented logics is so evident in all aspects of everyday life that it is now more accurate to refer to 'advanced liberalism' as a descriptor of post-industrial societies where the 'truths' of neoliberalism are popularly unquestioned and endorsed as common sense (Herrick 2011; Miller and Rose 2008). Within this political context new public health has become entangled in processes of marketisation of public provision, surveillance and auditing of performance in economic terms and the rolling back of the welfare state. To continue the river

metaphor, within advanced liberal governance the new public health agenda has lost sight of the need to build bridges to healthier lives and instead promotes individual responsibility for swimming competency. The central concern in this paper is to explore the complexities of advanced liberal governance that help explain discrepancies between policies that address health inequalities and the interventions designed to reduce them.

Although advances have been made, progress in addressing health inequalities in Britain has been, at best, modest (Black 1980; Whitehead 1988; Acheson et al. 1998; Marmot 2010). After being elected in 1997, New Labour made a public commitment to reduce social inequalities in health and strictly monitored progress made towards self-imposed inequalities targets. This led Whitehead and Popay (2010: 1235) to describe England as the 'longest natural experiment in attempts to implement a purpose-made action plan on health inequalities'. Evidence suggests that while this strategy achieved some relative success, austerity programmes imposed by successive Conservative governments since 2010 are reversing these achievements (Barr et al. 2017). Dorling (2013: 10) demonstrated that it is now necessary to go back to the recession of the 1880s to find a more severe health gap in British society – a situation he described as the 'scandal of our times'. In short, knowledge of health inequalities and the virtues of addressing the social determinants of health (SDoH) are well-established but have not led to interventions that bring about significant change. Hence, much can be learned from analysing the implementation of previous policies which had this as their stated aim.

Governing (Un)Healthy Bodies: Inequality and Lifestyle Drift

Contemporary delivery of new public health is distinct from previous approaches due to the emphasis on individual risk-management through 'lifestyle'. Health behaviours (e.g., regular physical activity, consuming a well-balanced diet) have thus come to the fore of health policies. A growing body of scientific research on health behaviours and chronic disease has informed the creation of an evidence base linking 'lifestyle behaviours' and biomedical measures of good health (Loef and Walach 2012). Subsequently healthy lifestyles have come to provide proxy measures through which individual and

collective health are defined in post-industrial societies, e.g., obesity rates, levels of (in)activity and fruit and vegetable consumption (Fullagar 2002).

This largely overshadows the well-established social gradient to these behaviours and the incidence of obesity, with low-socioeconomic status (SES) groups both less likely to perform beneficial behaviours (e.g., recreational physical activity) and more likely to be overweight/obese and to perform detrimental ones (e.g., smoking cigarettes) (Beenackers et al. 2012; Buck and Frosini 2012; Pickett et al. 2005). In the context of growing health inequalities this emphasis on lifestyle tends to undermine the significance of structural factors, social processes and local settings that both impinge upon people's health and their capacity to adopt 'healthy lifestyles' (Marmot 2010). Increasingly it is also recognised as having a detrimental influence on efforts to reduce health inequalities (e.g., Williams and Gibson 2017).

The lack of progress made in reducing health inequalities has been explained in part by a policy trend known as 'lifestyle drift'. This term evokes the river metaphor of the prevention parable and has been described as a situation whereby 'governments start with a commitment to dealing with the wider SDoH but end up instigating narrow lifestyle interventions on individual behaviours, even where action at a governmental level may offer the greater chance of success' (Hunter et al. 2010: 323). The process of lifestyle drift has previously been described without using this conceptualisation (e.g., Smith et al., 2009). Scholars such as, Graham (2009: 471), instead refer to the 'recurrent slippage' that occurs as policy statements move from overarching principles to strategic objectives. While the lifestyle drift concept is now established, the literature on this phenomenon is chiefly composed of short editorials (Baum 2011; Hunter et al. 2010; Popay et al. 2010; Marmot and Allen 2014). Powell et al. (2017) are a notable exception and argued lifestyle drift is an under-theorised social process. There is little empirical explanation of why it occurs or analysis of how different approaches to lifestyle interventions influence health inequalities.

Sociological analysis of local settings appears key to addressing this deficiency. Exworthy et al. (2002: 83) explain the relative autonomy of local practitioners and agencies can undermine the spirit and/or purpose of central policies and this makes an 'implementation gap' between national objectives and local action on health inequalities a likely outcome. Given the critical significance of lifestyle drift in the reproduction of health inequalities there is a need to further theorise how policy discourses play out in localised contexts and produce inequity as an embodied problem. Our specific focus is on the policy of targeting local areas identified as ill health 'blackspots' with area-based initiatives (ABIs) – this was fundamental to New Labour's commitment to addressing national health inequalities (Crawshaw et al. 2004: 343).

Nikolas Rose's work has been foundational to a well-established critique of the ways in which policy initiatives normatively position 'the community' as the site of local problems, and importantly solutions, as power works through a 'new spatialization of government' (Rose 1999: 136). The devolution of centralised State responsibility for public health to local authorities and non-government agencies in the UK is an example of how 'communities' are held accountable for solving problems related to health inequalities. Health problems, such as obesity, come to be framed through calculations of risk and benefit in ways that are infused with moralised assumptions about active citizenship and individual responsibility for lifestyle modification in a game of 'community-civility' (Rose 1999: 188).

Drawing upon a governmentality perspective, Crawshaw et al (2004: 345) analysed New Labour's ABIs and argued that while a community discourse may appear to offer more holistic social support 'responsibility for risk is decollectivised, shifting from a focus upon whole populations at the level of the state downwards towards smaller groups in communities and ultimately individuals'. The promotion of behaviour change by advocating adherence to a 'healthy lifestyle' is a key component of this process. The failure to identify the materiality of risk related inequalities of, for example, class, gender, ethnicity, is arguably why community-based dietary and physical activity interventions

generally have no or little effect on low-SES groups (Cleland et al. 2012; Everson-Hock 2013). Understanding how risks to health are mobilised through political rationalities that elevate individual agency also helps us understand how behavioural health promotion endures despite its ineffectiveness in reducing health inequalities (Baum and Fisher 2014). However, questions remain as to how and why national policies with explicit aims to address the SDoH end up drifting into the terrain of lifestyle when they are governing change in local contexts.

The WHO (2011) highlighted the importance of local governments to addressing the SDoH. This issue is particularly pertinent in England (and Britain more broadly) as the devolution of power to local governments continues apace following the 2014 Scottish independence referendum. Despite acknowledgment of the lifestyle drift trend, literature on the interpretation of the social determinants argument, and the implementation of related policies at a local level is sparse and as such it is necessary to draw from various international accounts.

Research by Lawless et al. (2016) with local council staff in Australia found that despite relatively high levels of agreement on uptake of ideas about the SDoH over half of the participants identified lifestyle *choices* as having the greatest effect on health. British research has identified the role of local decision makers working within systems and structures. Blackman et al. (2012: 56) found health inequalities were often seen as a 'Cinderella area' due to the pressure to deliver outcomes and demonstrate value for money in a culture of short-termism. Similarly, Orton et al.'s (2011) research with local, regional and national public health policy makers in cardiovascular disease found that many of them wanted to address the imbalance between upstream and downstream interventions. However, the medicalisation of the public health system and an over-riding emphasis on downstream targets and outcomes meant that they either had to side-line the issue of health inequalities or address it with downstream interventions. Having acknowledged this tension, it is important to point out that lifestyle interventions differ in distinct ways.

Gore and Kothari's (2012) research in Canada demonstrated that preventative strategies that focus on addressing the SDoH to promote healthy eating and physical activity were interpreted and delivered in markedly different ways at a local level. A minority of the 121 analysed interventions addressed – as instructed – the structural roots from which inequalities in adherence to health behaviours arise whereas the majority focused on educational programmes designed to promote individual lifestyle modification. Here two salient issues arise that require further consideration: (i) the role of the local context in the process of lifestyle drift and; (ii) the social processes that reproduce inequities in the design and delivery of lifestyle interventions.

This paper seeks to extend this inquiry by presenting ethnographic findings from a severely deprived area in England that – in line with New Labour policies of the time – became the focus of ABIs aiming to reduce national health inequalities. Findings demonstrate how the promotion of physical activity came to play a prominent role within the delivery of a policy that was presented publicly as dealing with the SDoH¹.

Methods

The empirical data are from an ethnography conducted by the first author. The research site was 'North Kingsland' (pseudonym), a low-SES neighbourhood in England and focus of ABIs implemented between 2000-10. Anonymity was stipulated as a condition of access by local gatekeepers to limit the potential for findings to be used in ways that detrimentally impact the area and people involved. Ethical approval was obtained from the relevant university ethics committee before 16 months of data-collection commenced from March 2012. The immersive characteristics of ethnography allow critical attention to be applied throughout the micro-macro scale and was thus deemed the most suitable method to investigate (in)consistencies between stated policy aims, local delivery and outcomes.

The epistemological underpinning of this research assumes multiple realities are constructed by the researcher and respondents, both independently and in cooperation. Through the analysis of empirical data, the researcher presents an account of observed phenomena. This is neither fixed nor incontestable, but to be successfully defended, it must be grounded in rigorous and honest academic endeavour. Data-collection primarily involved (participant-)observation recorded in fieldnotes that totalled in excess of 400,000 words and documented 230 fieldwork excursions (850.75 hours). During fieldwork, nine key local policy/intervention documents came to light. Analysis of these provided historical context and established criteria by which to assess the social impact of the ABIs. The findings also draw upon 14 semi-structured interviews conducted with local physical activity service providers and a senior manager at the local City Council. Fieldnotes and interviews were thematically coded with data-collection being refined and analysed inductively in line with a grounded theory approach informed by critical theory (Charmaz and Mitchell 2001). NVivo 10 was utilised to manage this dataset. Interviews were conducted towards the end of the data-collection phase. Questions were designed to address themes identified and coded throughout analysis of fieldwork materials. Interview participants were purposively selected for their relevance to exploring identified themes. Before discussing key themes it is necessary to present a picture of the field constructed from observations and local documents in order to illustrate how lifestyle drift was initiated in this local context. To maintain confidentiality pseudonyms are used throughout and local documents are cited but not formally referenced.

The Field as a Policy Context: Going with the Flow

Kingsland was awarded a New Deal for Communities (NDC) grant of approximately £50 million to be spent on regeneration over a ten-year period (2000-10). NDC regeneration was to bring about holistic change by investing £2 billion in five key areas: poor job prospects; problems with housing and the environment; high crime levels; educational under-achievement; and poor health. The 39 NDCs

targeted some of the most deprived areas in England and had a relatively positive influence on health inequalities (Stafford et al. 2014).

Kingsland was also designated as a Sport Action Zone (SAZ) which was to contribute to local regeneration between 2002-2007. The SAZ aimed to promote participation in sport and physical activity by increasing accessibility in deprived areas. SAZ discourse was typical of government through 'empowering' community with a stated aim to 'help local communities to help themselves' (Sport England 2006: 4). A third of the 12 SAZs were located in NDC areas. This was no coincidence as attracting funds from non-sporting sources, e.g., NDC, was a significant aim of the project (Sport England 2006). Therefore, in effect this intervention was designed to facilitate lifestyle drift and is thus key to understanding how this process occurred in Kingsland.

The Kingsland Community Association was formed to deliver the NDC programme with a democratically elected board mainly comprised of local residents. The Association also hosted the SAZ, which led to the NDC and SAZ initiatives becoming closely aligned. This was in line with the NDC approach to delivering health and social policy with partnership working as a central feature (Lawless 2004). Consequently, facilitating 'healthy living' came to play a prominent role within NDC regeneration in Kingsland.

The Index of Multiple Deprivation (2000) ranked Kingsland within the top 1% of the most deprived areas in England. Additionally, England is separated into 324 areas governed by local authorities and in 2013 the one which included Kingsland was in the top 10% of the most deprived. In short, Kingsland was a deprived subsection of a larger region characterised by relative deprivation. There were nearly 5,000 residential properties in Kingsland built around a park. Almost three quarters of these properties were owned by the Local Authority and rented as social housing through the welfare system. This research focused on the neighbourhood where the housing estate most severely affected by social deprivation was located. This was the main site of NDC and SAZ investment and known as North Kingsland.

The SAZ required a needs assessment and action plan (NAAP) to be conducted and led by community consultation. It established that many North Kingsland residents engaged in physical activity and others wanted to but stated significant barriers inhibited their participation, particularly the absence of a local swimming pool. Consequently, improving existing physical activity facilities and building new ones was prioritised and supported by NDC funds. This transformed North Kingsland into a relatively novel research site: a severely deprived area with numerous physical activity facilities and services.

These included, but were not limited to, a new leisure centre and swimming complex that received £1 million of NDC funds; 'The Elm' that encompassed a youth centre, multi-purpose games courts and football pitches; and offices for the SAZ team. All of these facilities were built along the top edge of the park within a short walk (<5 minutes) of the North Kingsland estate.

The end of the NDC and SAZ interventions marked a significant moment for physical activity provision in Kingsland. Originally the leisure centre had been made accessible to North Kingsland residents by offering subsidised entry-fees, a subsidised sessional crèche facility and numerous cost-free and subsidised targeted activities run by the SAZ team, e.g., one-to-one gym mentorship, weight-loss groups, youth activities. However, during observation these services had declined or ceased to exist entirely. The SAZ team split into two entities: (1) Keep-Fit – operated from the same office facilities but no longer specifically targeted local residents; (2) FIT-FRIENDS - commissioned by the NHS to provide city-wide weight-loss services with offices in the city centre. The Elm lost key managerial staff, no longer conducted outreach work in the community or ran many of the previously offered targeted activities. In the next section we analyse how these changes were implicated in this localised lifestyle drift through two key themes; *precarious partnerships* and *citizen shift*.

Findings and Discussion

The two key themes identified in this analysis examine the social processes that undermined the original intent to address health inequalities using ABIs and in so doing provide insight into the so called implementation gap. The drift towards lifestyle modification was produced through the

intersection of shifting policy agendas and management practices that came to govern how 'community' need was understood.

Precarious Partnerships

During the NDC-SAZ term, North Kingsland residents were targeted and promoting physical activity was incorporated into the upstream NDC strategy. Early local policy documents reflected a new public health approach that clearly recognised lifestyle modification required significant social intervention with one NHS document describing health as 'a shared responsibility between the Kingsland community and agencies'. The need to adopt this strategy was stated in the SAZ NAAP:

It has taken over fifty years to reach this level of deprivation and it will take more than two or three years to regenerate it. It will mean that agencies must work together in a joined-up way and must involve residents in this regeneration process, otherwise it will fail again.

The central role of the new Leisure Centre in local regeneration was framed in the local authority business and strategic development plans to 'ensure that issues around social inclusion and equalities are addressed so that everyone has the opportunity to access the facilities and that the local community benefits from the activity generated on the site'. These aims were to be achieved and sustained in part through working in partnership with external agencies. The Leisure Centre was described as a 'catalyst for the regeneration of Kingsland' that would be 'recognised for its achievement in forging close partnerships with agencies' of which the NDC and SAZ teams and the local community were specified.

Planning documents also stated that to 'ensure the establishment of a strong working partnership' community sports development officers would be based at the facility to implement programmes that 'directly answer needs identified by and for the local community'. Despite these initial plans, these staff were never actually based at the Leisure Centre. Instead meeting local needs relied upon separate service providers having the opportunity to meet, clarify joint goals and/or work together to

ensure collective responsibility for local lifestyle modification. However, a local steering group that facilitated this opportunity disbanded after the NDC term.

At that point, partnership working for the purpose of engaging local residents became particularly precarious because, without the local focus that came from the NDC-SAZ partnership and with the inevitable reduction in funds, service providers appeared to prioritise using their limited resources to achieve other aims – most evidently, securing a continued existence amidst severe reductions in public spending. This created tensions that were apparent when, in interview, Julie (Keep-Fit Manager) discussed the present state of local partnership working:

There's pockets of good examples of partnership working and then there's pockets where it certainly could be better. You used to have a Community Sports Network and that was for Kingsland you know and you had all the sports providers and physical activity providers sitting around the table and looking at how they develop things and that massively [deteriorated].

I think that people are very like, now that they are having to protect their service, they're becoming very insulated. I think that's the worst thing to do because, actually you know, if you worked more with partners you'd have more of an existence and profile and you might also be able to have a bigger impact as your service shrinks. I think a lot of services are becoming very insular and trying to protect, which in turn has a knock on effect on how you work together.

This shift in priorities was clear when, in interview, John (Head of Sport and Leisure Services at the City Council) evoked the discourse of austerity to explain the reduction in programmes delivered at the Leisure Centre that were specifically designed to support North Kingsland residents:

Doing more often costs more and in the current [economic] climate that's difficult to do. Really difficult to do. It's the toughest time I've known in 30 odd years...It's a fine balance in Kingsland because, in terms of the income, for every Kingsland resident you have you need to spring someone from outside Kingsland to balance the books and it is that fine line. I'd like to see us do more for Kingsland residents but on the other hand I have to consider the sustainability of the Centre and make sure that it still washes its face and that's a tough social dilemma at times.

During the period of this study austerity measures drastically reduced expenditure in key public services (e.g., leisure centres). Widdop et al. (2017) found that this left the majority of local authorities struggling to maintain services for those most in need and consequently had a disproportionately

negative impact on the physical activity of low-SES populations, particularly those living in deprived areas.

While Julie bemoaned the 'shrinking' effect that such measures had on local partnership working the need to expand her own service (Keep-Fit), beyond solely targeting North Kingsland residents, in order to sustain it post-SAZ funding had a similar effect. Her comments were typical of service providers initially established through the NDC-SAZ partnership:

If you are only sort of concentrating on one particular area within a city, then there's going to come a time when they'll see that that injection of capital or revenue, funding is a higher proportion than other areas. So it's about looking at 'Well there is still a need here, there is still a hell of a lot to address here. However, there are other areas.' So it's about bringing those other areas in to be able to then sort of look at your vision and write your funding applications.

Previously, patterns of local deprivation helped these providers secure funds for local projects, but after the NDC-SAZ term this kind of deprivation positioned residents as costly consumers to provide for during austere times. Lawless (2004) found that it was common for NDC sites to come to be thought of as 'cash-rich' and, as a consequence, funding agencies reduced their expenditure in them. Without NDC funding and operating under a backdrop of public sector cuts, service providers in Kingsland seemed incapable or unwilling to maintain their previous commitment to assume collective responsibility. Therefore, local partnerships deteriorated to the point where, in some instances, they considered themselves to be in competition.

When other service providers planned to organise local activities outside of the Leisure Centre, or even continued subsidised activities within it, Karen (Leisure Centre Manager) increasingly interpreted this as potentially threatening the Centre's capacity to sustain itself financially. Karen regularly adopted this narrative:

There's a problem with this place [North Kingsland] being flooded with things. Me and Julie have been friends since school, but professionally we will fall out if she puts [exercise] classes on [in the Park]; I'll get a meeting with her and her boss and say 'What are you doing?' because we offer that and if they put things on there, it will be competing with us and that messes up everyone's figures, because no one hits the numbers that they want, or need. (Fieldnotes: 28/6/2012)

The irony is that it was the reluctance of Leisure Centre management to work in partnership with external providers that left them with few options but to utilise other sites, e.g., the park, in order to offer equitable service provision. Instead of viewing other service providers, e.g., Keep-Fit, as partners with which a collective responsibility was shared, Karen treated them no differently to any other group that used the Centre. As such, hiring space at a subsidised rate, or even for free, (a previous outcome of partnership working) was no longer offered to these providers. In line with John's previously quoted comments, partnership working for the purpose of sustaining equitable provision was deemed too costly to sustain and thus addressing health inequalities was no longer considered feasible. The finding of similarly aligned service providers competing rather than working in cooperation is analogous to findings elsewhere (e.g., Milbourne 2009). However, the novelty of this finding is in what it illustrates about how responsibility for public health provision in advanced liberal governance shifted through changing policy priorities and practices that divided rather than united services.

In part, partnership working declined because local residents became less important to the continued existence of local service providers. These partnerships are conceptualised here as '*precarious partnerships*' because inter-agency working was proposed in policy as a mechanism through which to facilitate sustained support for local residents post-intervention and in the absence of targeted funding. However, during observation, partnership working appeared to be reliant upon the very factor it was supposed to compensate for (i.e., short-term funding). As services prioritised their own continued existence in austere times, the responsibility for increasing physical activity in this deprived neighbourhood drifted further downstream past local agencies that initially came into existence as part of a strategy to achieve this aim.

This highlights inherent contradictions in the discursive construction of community provision (leisure services) as (i) a resource that enables inequality to be addressed by relieving the constraints on individual agency and also (ii) as a resource that individuals must access *en masse* through their individual exercise of agency to secure their own conditions for healthy living. The precariousness of

community resources as public infrastructure for healthy living is intimately connected to the broader conditions of uncertainty that arise from austerity-driven policy agendas and market-based solutions to the effects of structural inequalities (McKee et al. 2017). This example demonstrates the limitations of assumptions about the existence of ‘natural good will’ and essentialist ideas of community partnerships that are premised on notions of collaboration and collective provision. This tension illustrates how the individualisation of responsibility for overcoming health inequality does not stop at the point at which policies drift into the terrain of lifestyle. Responsibility for lifestyle modification came to be decollectivised over time and this further marginalised a low-SES population in a process we conceptualised as *citizen shift*.

Citizen Shift

Service providers often articulated a sense that there was a collective responsibility to promote physical activity locally, yet none of them seemed to feel that it was *their* responsibility to ensure this happened. This may have been a consequence of previous attempts to form successful partnerships that had consistently failed. However, the overarching issue appeared to be that they all had different and competing priorities now that the NDC-SAZ term was over. There was a dominant local narrative, rehearsed by service providers and residents alike, that the Leisure Centre was no longer ‘doing what it was built for’ because it did not honour the commitment to work in partnership with other service providers and local residents. However, service providers would frequently speak about how others were not fulfilling their responsibility to local residents whilst leaving unacknowledged their own exposure to these accusations.

In this sense, responsibility for engaging North Kingsland residents and providing equitable services was an ever present discursive formation concerning health, but rarely translated into organisational practice. The desire to decollectivise responsibility was well captured in Karen’s (Leisure Centre Manager) lament:

This place should be having a bigger impact; it's a fucking massive, fucking Leisure Centre for Christ sake. We should be more involved with it. People should be in here. (Fieldnotes: 30/8/2012)

Karen did not consider it *her* responsibility to ensure local residents were 'in there', but she felt they should be. Other service providers felt that it was indeed her responsibility to make the Leisure Centre more accessible – but they did not or could not actively form partnerships with her in order to facilitate this. Consequently responsibility for participation was consistently pushed further downstream to the residents themselves and thus reflected the tendency for new public health interventions to individualise responsibility for health.

Shifting responsibility, and ultimately individualising it, is of course an implicit aim of advanced liberal governance. This is why Conway et al. (2007: 225) termed 'community' a 'bargain discourse' and Fullagar (2002: 71) stated that governments view physical activity as the 'best buy in public health'. Almost inevitably a culture of blame shifting emerges as fingers are pointed at individuals, whether that be the manager of a service provider, or a sedentary resident. Similarly, Powell et al. (2017) found that in an attempt to manage the threat posed to future funding and their own employment, physical activity service providers in a deprived region of north England explained low participation rates as resulting from the irresponsible lifestyles of local residents.

During the NDC-SAZ term, there was evidence that many services in North Kingsland were provided through local partnerships that attempted to address the structural barriers that inhibit the physical activity of low-SES populations. However, during fieldwork it was apparent that availability of funding largely determined such partnerships and without it partnership working was, at best, precarious and, at worst, non-existent. Sam (Operational Manager at The Elm) eloquently summed up this problematic process one evening at a free football session mainly attended by young men from the North Kingsland estate:

When the money was there everything was successful, but the big, bashed drum isn't in Kingsland anymore. They used to go out and get people involved but now it's different. (Fieldnotes: 16/11/2012)

The reality of post-NDC-SAZ priorities was echoed by Karen (Leisure Centre Manager):

At the beginning, we had all this money and they would just give it to us when we wanted it. It was like we'd won the lottery. But it's different now, things have changed and we have to do things differently. (Fieldnotes: 27/7/2012)

After the process of lifestyle drift has occurred it is important to recognise the processes through which lifestyle interventions can further individualise the SDoH in delivery: a process conceptualised here as '*citizen shift*'. Lawless (2004: 393) specified that NDC partnerships could be problematic because on occasion they seemed 'not to have thought out inherent contradictions in proposals'. These were evident in existing physical activity services provided in North Kingsland. Perhaps the most striking examples were the sustainability strategies that went beyond partnership working. These usually involved conflating the *capacity* to pay for services with a *willingness* to.

Whilst seemingly contradictory, this construction of the local citizen is consistent with the way, Clarke (2004: 39) argued, contemporary politics positions citizen identities through three differentiated figures: the tax payer, the scrounger and the consumer. When I spoke to service providers about the reduction in local subsidies at the Leisure Centre they told me this had always been the plan (this was confirmed in local documents). The narrative was consistent: local subsidies were initially substantial in order to entice local residents to use the facility. The expectation was that residents would come to 'value' what they did there enough to then pay more when the subsidies reduced. As Clarke (2004: 39) explained 'the idea of the consumer has added new dimensions to the way the public interest is being represented. Above all, "the consumer" is held to mark a shift from "passive recipient" to "active choice maker" in relation to services'.

Rather than offering adequate support, the initial subsidy was a strategy to 'enlighten' a low-SES population to support them to make 'better choices'. Or as the SAZ slogan stated, to help them 'help themselves'. Similarly, local agencies advised their instructors to introduce participation fees at groups that initially offered free services even when such income was not required to sustain the service. The

discourse used was one of participants 'taking ownership'. While there may be some legitimacy to this argument in relation to more affluent populations, in this context it undermines the aim of promoting lifestyle modification in a severely deprived neighbourhood. This sustainability strategy is indicative of the '*citizen shift*' process, individuals were re-positioned from citizens with a right to public services that enhance health, to consumers who exercise their responsibility to pay. This process of subject formation is produced through advanced liberal rationalities that enable service providers to envisage individual agency as the downstream starting point for change and ignore evidence on upstream strategies to address inequality. Consequently, initial efforts to realise the health promoting potential of new public health interventions (by supporting large-scale lifestyle modification with necessary social infrastructure) were undermined by lifestyle drift becoming increasingly individualised at the local level.

Even the responsibility for the promotion of available local services was shifted from providers to participants. Due to the tensions between local service providers the few low-cost and free activities that external agencies still ran at the Leisure Centre became 'open secrets' in that they were not openly promoted and were reliant on 'word of mouth'. It is common practice for word of mouth to act as the most utilised form of awareness-raising for local services (Everson-Hock et al. 2013). However, in the context of questions around responsibility, this offers another example of how responsibility can be decollectivised and shifted to the citizen consumer. When funding was more plentiful, community consultation and outreach work to engage North Kingsland residents was common practice. However, there was no evidence of this during fieldwork. Rather, the numbers of participants attending the few remaining groups were left to dwindle.

The shifting of responsibility from provider/partner to local citizens was perhaps best illustrated by the story of a mobile phone the SAZ team had used to promote women's weight-loss groups. The phone number was put on promotional leaflets. When I spoke to one of the group's past instructors, Lindsay, about why these leaflets were not more widely distributed to promote the, previously

popular but then sparsely attended, service she told me that they would be of little use even if they were. She explained that the phone was now switched off and abandoned in a desk drawer in her old office. Local residents would have to find out about (and promote) this open secret themselves and if they did not the threat to stop running the group was ever present (and eventually realised).

Lindsay had grown up in North Kingsland and had established the weight-loss group by engaging with the local community. She had since been made redundant and replaced with another instructor who delivered it as part of FIT-FRIENDS' city-wide programme. When I spoke to her she was angry about the current state of affairs:

I can't believe none of them actually sat down and thought 'Well, why was the numbers dropping, what's not working, how can we make it better?' I can't believe that and it feels, not personal, but I'm like, 'That's my group' and they've killed it...I think what they need to look at is if a popular group dies, why is that?

Lindsay's accusation that a previously well-attended group that had successfully engaged North Kingsland residents had been left to wither is a fitting description of the effects of individualised responsibility on local physical activity participation more generally. Due to the socio-economic characteristics of North Kingsland, facilitating local participation was to some extent reliant upon the needs of residents being met by services that came about through the NDC-SAZ initiatives. However, sustainability strategies for these services increasingly shifted responsibility to residents alone. Therefore, the inhibitory social factors that these services had once attempted to address were subsequently left to individuals to overcome by themselves and thereby, to some extent, local residents were set up to fail (and to be blamed for doing so).

Karen's comments demonstrate how normalised this shifting process became and thus how far local service provision had reconfigured the discourse of collective responsibility stated in initial policy documents:

I believe there is a clear pathway to every single person's house in Kingsland to [the Leisure Centre], to the [Keep-Fit Team], to the [Library], to The Elm, you know, to everything. And it is their responsibility - and people do need to take responsibility for their health, you know.

The process of '*citizen shift*' was normalised within this localised policy context as a repositioning of responsibility from service providers to residents where the SDoH became a 'backdrop' to the elevated realm of consumer choice. It sits within a larger process of inequitable modification to local services over time conceptualised elsewhere as 'inequity drift', and is an example of how citizens of deprived areas can be further disadvantaged by intervention-generated outcomes (Williams 2017). These processes were facilitated by inadequate sustainability strategies of advanced liberal governance (deprivation cannot be addressed by a citizen-consumer model) and short-term political vision that undermined a longer term focus on SDoH.

Conclusion

By analysing Kingsland specifically as a local context of lifestyle drift it has been possible to further the inquiry, and deepen the analysis, of this increasingly cited policy process. This paper contributes to critical public health debates by: (i) illustrating with empirical findings how lifestyle drift is implicated in the realisation of the implementation gap between policy objectives and achievements in relation to reducing health inequalities (ii) highlighting that lifestyle interventions are not by definition downstream interventions but rather the salient factor in relation to reducing health inequalities is whether approaches to lifestyle modification are socially- or individually-orientated and (iii) revealing examples of the social processes that reproduce inequities in the design and delivery of lifestyle interventions. More broadly, this analysis contributes to the critique of advanced liberal governance by paying specific attention to how power operates through normalised 'truths' about citizen rights and responsibilities and why these political rationalities impede policy aims to more significantly influence social change to reduce health inequalities.

By identifying the genesis and development of lifestyle drift within the particularities of a local context, we propose original conceptualisations of *precarious partnerships* and *citizen shift* to better understand the dynamics at work. In light of Bell and Green's (2016) critique of neoliberalism as an

overgeneralised concept, we argue for more specific, fine grained analysis of the historical, social and political relations that shape local service provision in order to identify contradictions, tensions and possibilities for change. In essence lifestyle drift occurred in North Kingsland because an ABI (SAZ) specifically designed to promote physical activity with funds sourced from non-sporting/physical activity agencies was paired with one (NDC) tasked with addressing the SDoH. However, highlighting the genesis of this process only illuminates at which point the issue of reducing health inequalities was pushed into the metaphorical river, rather than its journey downstream. Further analysis of the NDC-SAZ partnership formed in North Kingsland sheds light on the more nuanced social relations that often fall into the shadow of lifestyle drift critiques and the false binaries common to health promotion and health inequalities debates: agency-structure; people-places; individual behaviours-social determinants.

Arguably the example of North Kingsland provides evidence for the potential usefulness of incorporating lifestyle interventions (e.g., physical activity promotion) into an upstream regeneration strategy (e.g., NDC). The partnership between the NDC and SAZ initiatives led to physical activity initially being approached as a behaviour that is largely socially determined and consequently promoted with upstream intervention, e.g., addressing material inequities. In this sense the influence of a policy specifically designed to address the SDoH (NDC) acted like a bore tide that went against the current of advanced liberal governance and as a result pushed lifestyle modification upstream. This saw lifestyle modification addressed as a collective, rather than individual, responsibility.

While this may have been the case the effects were short-term. Lifestyle interventions have a tendency to exacerbate, rather than reduce, health inequalities unless interventions specifically target and meet the needs of under-served and disadvantaged groups (Frohlich and Potvin 2008). Therefore, in North Kingsland the potential of providing a leisure centre 'intervention' to further the aim of reducing national health inequalities could only be realised with a long-term commitment to equitable service provision. This did not happen.

In line with other critiques of the discursive construction of 'community' through advanced liberal governance, in North Kingsland responsibility was ultimately decollectivised. *Precarious partnerships* formed the shaky foundations of sustainability strategies and the effectiveness of these relationships appeared to be predicated on the availability of targeted, time limited funds. Once ABI funding was spent local service providers, then operating within the strictures of a national austerity programme, no longer targeted North Kingsland residents and consequently reneged on previous commitments to address physical activity as a collective responsibility. Instead, responsibility for overcoming the SDoH was increasingly shifted to individual local citizens and normalised. This emphasises the limitations of local action on health inequalities when there is not more sustained national level action on the SDoH. Similarly, it illustrates some of the processes through which austerity exacerbates inequalities by facilitating lifestyle drift and fostering inequitable service provision.

The conceptualisation of *citizen shift* is seen as a necessary extension to understand the complex process of lifestyle drift because changing notions of agency, responsibility and risk are central to the construction of individual and social action. It highlights that once policy has drifted into the terrain of lifestyle, the currents of advanced liberal governance are liable to take local interventions downstream and ultimately shift responsibility to individual citizens. This conceptualisation could usefully inform critical reflection on policy and intervention design to mitigate inequitable practice by making visible the assumptions about individual action that underpin theories of change common to contemporary lifestyle interventions.

Footnotes

1. The 'New Deal for Communities' launched in the UK in 1998 as part of a policy of area-based intervention designed to reduce national health inequalities by focusing on the SDoH. This 'branding' deliberately echoed the terminology of F.D. Roosevelt-era American 'New Deal' social programmes publically celebrated for helping to bring the nation out of the Great Depression of the 1930s with socioeconomic regeneration and social welfare.

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